APPLICATION FOR FOSTER FAMILY HOME LICENSE

State Form 10100 (R10 / 6-06) / CW 0317
DEPARTMENT OF CHILD SERVICES

☐ **Foster Family Home License**
- ☐ Therapeutic
- ☐ Special Needs
- ☐ Regular

County

CENTRAL / LOCAL OFFICE USE ONLY

Enter resource ID number assigned by the Indiana Child Welfare Information System (ICWIS). If the number is less than 9 digits, use zeros for first spaces.

INSTRUCTIONS: Include the full name of all persons living in your home at present. For further entries, use the reverse side of this form.

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PLACE OF BIRTH	RELATION TO FAMILY	OCCUPATION OR SCHOOL GRADE	NAME OF EMPLOYER
Applicant A						
Applicant B						
Children						
Others						

Present address *(number and street, city, state, and ZIP code)*

Directions to home

Telephone number *(home)* ( )	Telephone number *(office)* ( )	Number of children for whom you want to provide care.	Age and sex

Please indicate the special needs characteristics of the children for whom you would consider providing care.

- ☐ None
- ☐ Child 2 years of age or older
- ☐ Medical / physical challenge
- ☐ Mental / emotional challenge
- ☐ Behavior challenge
- ☐ Adolescent
- ☐ Educational challenge
- ☐ Member of sibling group of 2 or more children, at least 1 of whom is 2 years of age or older and will be placed with the sibling group in the same home.

What led you to apply for a foster family home license?

- ☐ T.V.
- ☐ Radio
- ☐ Internet
- ☐ Newspaper
- ☐ Billboard / poster
- ☐ Family / friends
- ☐ Licensed child placing agency / list
- ☐ State-sponsored recruitment activities
- ☐ Faith-based organization
- ☐ Other *(specify)*

Reasons for wanting to care for children in need of services:

Have you ever applied for a foster family home license? ☐ Yes ☐ No	If Yes, from whom?
Have you ever cared for / fostered a non-related child? ☐ Yes ☐ No	If Yes, please explain:

How many children do you have of your own? Applicant A _____ Applicant B _____	Family income per month $	Religion Applicant A _____ Applicant B _____

Place of marriage	Date of marriage (*month, day, year*)	Number of rooms in your home	Do you have a yard? ☐ Yes ☐ No	Race Applicant A _____ Applicant B _____

Continued on reverse side

Please give, as references, the names of your physician and four persons (non-relatives) who know your family life.

NAME	STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER
Name of physician			( )
			( )
			( )
			( )
			( )

Other states in which applicant has resided:

Maiden or married names / aliases used:

Applicant A _____

Applicant B _____

If applicant has been named in any CPS reports as having committed any act of child abuse / neglect as determined by the Department of Child Services, this may be grounds for revocation or denial of a license.

Has applicant been named in any substantiated or indicated cases of child abuse and neglect as determined by Child Protection Services in Indiana or in any other state?

☐ No If yes, what state(s)? _____

☐ Yes If yes, what year? _____ If yes, what county(ies)? _____

Please provide details.

I certify that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge.

Signature of applicant A	Date signed (*month, day, year*)	Signature of applicant B	Date signed (*month, day, year*)

Use for additional entries from front page, if required